

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		16409	STATE OF MARYLAND CERTIFICATE OF DEATH		
County..... <i>Wicomico</i>		(No.)	Registration Dist. No. <i>933</i>		
Village or City..... <i>Salisbury</i>		<i>No Division</i>	St. <i>9th Dist.</i> , Ward <i>1</i>		
2 FULL NAME..... <i>Elizabeth H. Bell</i>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	6 DATE OF BIRTH <i>Mch 17th</i> (Month) (Day) (Year) <i>1849.</i>		
7 AGE <i>66 yrs. 5 mos. 19 ds.</i>	If LESS than 1 day, _____ hrs. OR min. ?		18 DATE OF DEATH <i>September 6</i> (Month) (Day) (Year) <i>1915.</i>		
8 OCCUPATION (a) Trade, profession, or particular kind of work. <i>None</i>	9 BIRTHPLACE (State or country) <i>Maryland</i>		17 I HEREBY CERTIFY, That I attended deceased from <i>August 17, 1915, to September 6, 1915,</i> that I last saw him alive on <i>September 6, 1915</i> , and that death occurred on the date stated above, at <i>5 P.M.</i> The CAUSE OF DEATH* was as follows:		
10 NAME OF FATHER <i>William Gubly</i>	11 BIRTHPLACE OF FATHER (State or country) <i>Maryland</i>		19 DURATION <i>1 yr. 1 mos. 1 ds.</i>		
12 MAIDEN NAME OF MOTHER <i>Jane Sommers</i>	13 BIRTHPLACE OF MOTHER (State or country) <i>Maryland</i>		20 CONTRIBUTORY SECONDARY <i>Glo. colic - acute</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (informant) <i>William H. Bell</i>					
(Address) <i>702 N. Division St., Salisbury Md.</i>			15 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds.		
16 PLACE OF BURIAL OR REMOVAL <i>Park Cemetery, Salisbury Md.</i>			17 DATE OF BURIAL <i>Sept. 8th 4 P.M., 1915.</i>		
18 UNDERTAKER <i>The Hill & Johnson Co.</i>			19 ADDRESS <i>Salisbury Md.</i>		
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.					

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

REVISED UNITED STATES STANDARD

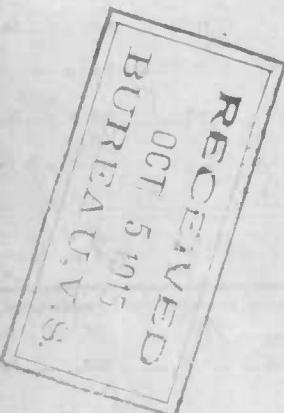
CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dull laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic voluntary heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anesthesia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malnutrition," "Old Age," "Shock," "Tranumia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

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1 PLACE OF DEATH
County Wicomico 16010 (S)

Village or City near Sharptown

2 FULL NAME Cook

PERSONAL AND STATISTICAL PARTICULARS				
SEX <u>Male</u>	4 COLOR OR RACE <u>Col.</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)		
6 DATE OF BIRTH		Sept. 12, 1915	(Month)	(Day) (Year)
7 AGE	0 yrs. 0 mos. 0 ds.	If LESS than 1 day 0 hrs. OR 0 min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry business, or establishment to which employed (or employer)				
9 BIRTHPLACE (State or country) <u>Md.</u>				
10 NAME OF FATHER <u>Clarence Cook</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>				
12 MAIDEN NAME OF MOTHER <u>Virgie Quinton</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Signature) <u>Clarence Cook</u> (Address) <u>Sharptown Md.</u>				
15 Filed <u>9/12, 1915</u> W. C. Mann				

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 335

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

St. Ward) Cook

MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH	9 / 12 / 1915	(Month)	(Day)	(Year)
17 I HEREBY CERTIFY, That I attended deceased from	191	to	191	
that I last saw h	alive on	191	191	
and that death occurred on the date stated above, at _____ m.				
The CAUSE OF DEATH * was as follows:				
<u>No doctor in attendance</u>				
<u>No one in attendance</u>				
<u>Still-Born</u> (Duration) yrs. mos. ds.				
Contributory Secondary				
(Signature) <u>Walter C. Mann</u> Reg. #. <u>9/12, 1915</u> (Address) <u>Sharptown Md.</u> (Duration) yrs. mos. ds.				
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)				
At place of death yrs. mos. ds.				
Where was disease contracted, if not at place of death?				
Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL				
DATE OF BURIAL				
ADDRESS				
UNDERTAKER				
W. W. Shaver & Sons, Sharptown				

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

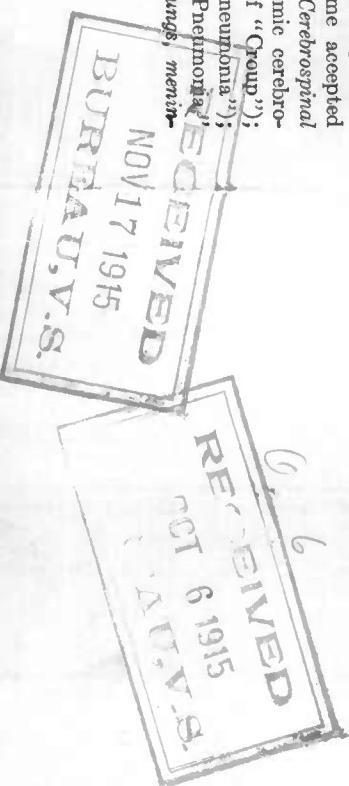
Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples:

Cerebrospinal fever (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia" unqualified, is indefinite); *Tuberculosis of lungs*, *meningitis*.

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds., *Bronchiopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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sent out for
signature of Doc. Reg.



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1 PLACE OF DEATH		16011	STATE OF MARYLAND
County <u>Wicomico</u>			CERTIFICATE OF DEATH
Village or City <u>Salisbury</u>		P. G. Hospital (No.) <u>Camden Dist.</u>	Registration Dist. No. <u>333</u>
			St. 13 Ward)
2 FULL NAME		<u>Harry Crockitt</u>	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED	6
<u>Male</u>	<u>Black</u>	<u>SINGLE</u>	<u>Single</u>
7 DATE OF BIRTH		<u>Not known</u> , I (Month) (Day) (Year)	
8 AGE		<u>About 28 yrs. m m ds.</u>	
		If LESS than 1 day, hrs. OR min. ?	
9 OCCUPATION		<u>Labover</u>	
(a) Trade, profession, or particular kind of work.			
(b) General nature of industry, business, or establishment in which employed (or employer)			
10 NAME OF FATHER		<u>Daniel Crockitt</u>	
11 BIRTHPLACE OF FATHER (State or country)		<u>Delaware</u>	
12 MAIDEN NAME OF MOTHER		<u>Not known to me</u>	
13 BIRTHPLACE OF MOTHER (State or country)		<u>Laurel Del.</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			
(Informant) (Address)		<u>Alvin White Laurel Del.</u>	
Filed <u>Sept 20, 1915</u>		Signature <u>May Turner</u>	
		Title <u>Deputy Registrar</u>	
If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.			
16 DATE OF DEATH			
<u>Sept. 19</u>		(Month)	(Day) <u>19</u>
, 1915 (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Sept. 18</u> , 1915, to <u>Sept. 19</u> , 1915,			
that I last saw him alive on <u>Sept. 19</u> , 1915,			
and that death occurred on the date stated above, at <u>4 P.M.</u>			
The CAUSE OF DEATH* was as follows:			
<u>Intestinal perforation</u>			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)			
At place of death		Yrs. <u>1</u>	mos. <u>4</u> ds.
In the State		Yrs. <u>1</u>	mos. <u>4</u> ds.
Where was disease contracted, If not at place of death?		<u>Sussex Co. Del.</u>	
Former or usual residence		<u>Sussex Co. Del.</u>	
19 PLACE OF BURIAL OR REMOVAL			
<u>Laurel Del.</u>		DATE OF BURIAL <u>Sept. 21, 1915</u>	
20 UNDERTAKER			
<u>H. O. & E. B. Riggan</u>		ADDRESS <u>Laurel Del.</u>	

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Contingent," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Hanover Co.

16012

18C1

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 3305

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Mardela (No.)

2 FULL NAME

Adam Dashill

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)MaleBlackSingle

6 DATE OF BIRTH

Sept201815

(Month)

(Day)

(Year)

7 AGE

yrs.

mos.

ds.

If LESS than
1 day, hrs.
OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

Charles C. Dashill

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Adda Weatherby

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles C. Dashill

(Address)

Mardela

15

Filed

, 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 25

, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191 , to , 191 ,

that I last saw h alive on , 191 ,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

General Debility

(Duration) yrs. mos. da.

Contributory
Secondary(Signed) I. L. English Registrar (Address) Mardela Md.
Sept 25 1915

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. da. In the State, yrs. mos. da.

of death yrs. mos. da. Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Col Cemetery Sept 25 1915

DATE OF BURIAL

20 UNDERTAKER

Hicks Waller ADDRESS Mardela

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

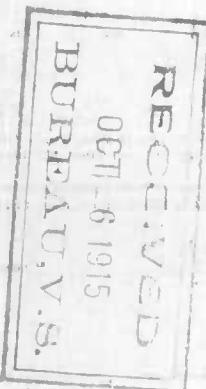
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ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (frame origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-gonital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH		
County	16013	
Village or City	Hebron	
2 FULL NAME Anna H. Davis		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX Female	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married
6 DATE OF BIRTH		Dec 28, 1870 (Month) (Day) (Year)
7 AGE 44 yrs. 8 mos. 20 ds.	If LESS than 1 day, ____ hrs. OR ____ min.?	
8 OCCUPATION (a) Trade, profession, or particular kind of work House wife (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) Maryland		
10 NAME OF FATHER Lambert Hall	11 BIRTHPLACE OF FATHER (State or country) Maryland	
12 MAIDEN NAME OF MOTHER Amy Danaway	13 BIRTHPLACE OF MOTHER (State or country) Maryland	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) H. S. Phillips (Address) Hebron Md.		
15 Filed Sept 28, 1915 Signature	H. S. Phillips	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 338

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 18, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1915, to Sept 18, 1915, that last saw her alive on 18th, 1915,

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) yrs. mos. ds.

Contributory
Secondary

(Disease) yrs. mos. ds.

(Signed) H. S. Phillips, M.D.
Sept 18, 1915 (Address) Hebron Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. To the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Family burial
DATE OF BURIAL Sept 20, 1915

20 UNDERTAKER P. T. Station
ADDRESS Delbyville Del.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age.

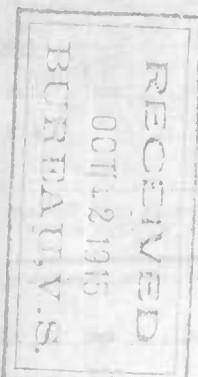
For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dairy laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housewife*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosches*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-sentil," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicæmia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Wicomico

16914

79

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 886

St. _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Delmar (No. _____)2 FULL NAME Sarah Jane Deshields

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, DIVORCED (Write the word) <u>MARRIED</u>
------------------------	-----------------------------------	---

6 DATE OF BIRTH <u>Jan</u>	7 AGE <u>28 yrs. 8 mos. 13 ds.</u>	8 OCCUPATION <u>House keeping</u>
-------------------------------	---------------------------------------	--------------------------------------

IT LESS than
1 day, ____ hrs.
OR ____ min. ?

6 DATE OF BIRTH <u>Jan</u>	7 AGE <u>28 yrs. 8 mos. 13 ds.</u>	8 OCCUPATION <input checked="" type="checkbox"/> (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) <u>" " "</u>
-------------------------------	---------------------------------------	---

9 BIRTHPLACE (State or country) <u>Maryland</u>	10 NAME OF FATHER <u>John W. Marie</u>
---	--

11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>	12 MAIDEN NAME OF MOTHER <u>Coatloawn</u>
---	---

13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>	14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Maggie Truett</u> (Address) <u>Delmar Dela</u>
---	--

15 Filed <u>Sept 2, 1915</u> by <u>W. Y. Duran</u>	REGISTRAR
---	-----------

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Sept 1, 1915

17 I HEREBY CERTIFY, That I attended deceased from
Sept 1, 1915, to Sept 1, 1915,
that I last saw her alive on Sept 31, 1915,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Acute cardia

Recurring attack for 3 yr (Duration) yrs. mos. ds.

Contributory None
Secondary

(Duration) yrs. mos. ds.

(Signed) J. H. Gandy, M. D.
Sept 1, 1915 (Address) Delmar Dela

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. mos. ds. In the _____ State _____ yrs. mos. ds.

Where was disease contracted,
It not at place of death?

Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL <u>G. M. Cem Vienna Md</u>	DATE OF BURIAL <u>Sept 1, 1915</u>
---	---------------------------------------

20 UNDERTAKER <u>M. W. Elin</u>	ADDRESS <u>Delmar Dela</u>
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REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Seuile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *scaphis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 2 1915

BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Hanover</u>		16015
Village or City <u>Wetogin</u>		(No. <u>14</u>)
2 FULL NAME <u>John Deswutch</u>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>Male</u>	4 COLOR OR RACE <u>C</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>No record</u>		<u>Sept</u> <u>7</u> , <u>1888</u> (Month) (Day) (Year)
7 AGE <u>5</u> yrs — mos. — ds.	If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>		
9 BIRTHPLACE (State or country) <u>Pa.</u>		
10 NAME OF FATHER <u>Norris Deswutch</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Philadelphia</u>		
12 MAIDEN NAME OF MOTHER <u>Amelie Destuech</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Amelie Deswutch</u> (Address) <u>Wetogin Pa.</u>		
15 Filed <u>Sept. 8, 1915</u>	Lucy L. Wallin	REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 337

St. _____ Ward _____

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 7, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
Aug 28, 1915 to Sept 7, 1915,
that I last saw him alive on Sept 6, 1915,
and that death occurred on the date stated above, at 3 A m.

The CAUSE OF DEATH was as follows:

Dependency.Contributory
Secondary Consumption

(Duration) yrs. mos. ds.

(Signed) W. E. Mead, M. D.
Sept 7, 1915 (Address) Franklin St., Hanover*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-
DENTAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)At place _____
of death _____ yrs. _____ mos. _____ ds.

In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
if not at place of death?Former or
usual residence _____19 PLACE OF BURIAL OR REMOVAL
Wetogin Cemetery DATE OF BURIAL
Sept 8, 191520 UNDERTAKER G. MorrisADDRESS Bivalve

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the most causative death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FILED
OCT 5 1945
BURGAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Mocomico

16016

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 337

St.: _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Retipquin (No.)2 FULL NAME
Melissa C Dunn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH

May 2, 1863

(Month)

(Day)

(Year)

7 AGE

58

yrs.

mos.

ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work..(b) General nature of Industry,
business, or establishment in
which employed (or employer)House-work

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Richard Coulbourne

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Dont know

13 BIRTHPLACE OF MOTHER

(State or country)

Dont know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Esther Dunn(Address) Retipquin Md.

15

Filed Sept. 2, 1915 Lucy & Walter

Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 1, 1915

Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Aug 31, 1915, to Aug 31, 1915,that I last saw her alive on Aug 31, 1915.and that death occurred on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) — yrs. — mos. — ds.Contributory
Secondary(Duration) — yrs. — mos. — ds.(Signed) J. R. Wren M. D.
Sept. 1, 1915 (Address) Transkeide Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

Bivalve Co. County DATE OF BURIAL Sept 2, 1915

20 UNDERTAKER

C. G. Meirick ADDRESS Bivalve Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

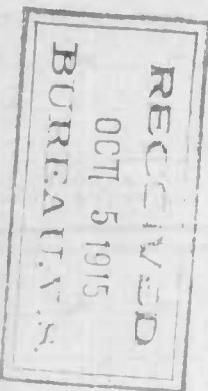
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Houswife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 d.; Bronchopneumonia (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., scaphis, tetanus) may be stated under the head of "Contribution." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH
County Micromies

Village or City Salisbury (No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant of Virgil Elliott

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word) Single

6 DATE OF BIRTH

Sept - 10, 1915
(Month) (Day) (Year)

7 AGE

yrs. mos. 1 2 ds. If LESS than
1 day, ... hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work.

None

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country) Micromies Cols.

10 NAME OF FATHER

Virgil Elliott

11 BIRTHPLACE OF FATHER

(State or country) Micromies Cols.

12 MAIDEN NAME OF MOTHER

Millie Parsons

13 BIRTHPLACE OF MOTHER

(State or country) Micromies Cols.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Virgil Elliott

(Address) Salisbury Md.

15

Filed Sept. 12, 1915 by May Turner.

Deputy, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 11, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Sept. 11, 1915, to Sept. 11, 1915,
that I last saw him alive on Sept. 11, 1915,

and that death occurred on the date stated above, at SP m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) yrs. mos. 1 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) D B Drotter, M. D.

Sept. 12, 1915 (Address) Salisbury Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

Parsons Cemetery Sept. 12, 1915

DATE OF BURIAL
Sept. 12, 1915

20 UNDERTAKER

ADDRESS

The Hill & Johnson Co Salisbury

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocer*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Wisconsin

16018

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 330

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Hebron (No.)**2 FULL NAME** William H. Ennis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male **4 COLOR OR RACE** Blacks **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Single
(Write the word)

6 DATE OF BIRTHAug 8, 1910
(Month) (Day) (Year)**7 AGE**5 yrs. 1 mos. 13 ds.
It LESS than
1 day, ____ hrs.
OR min. ?**8 OCCUPATION**

- (a) Trade, profession; or particular kind of work.
 (b) General nature of Industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE(State or country) Wisconsin**PARENTS****10 NAME OF FATHER**Charley Ennis**11 BIRTHPLACE OF FATHER**
(State or country) Wisconsin**12 MAIDEN NAME OF MOTHER**Mary Moore**13 BIRTHPLACE OF MOTHER**
(State or country) Wisconsin**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**(Informant) Charley Ennis(Address) Hebron**15**Filed 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATHSept 21, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1915, to Sept 21, 1915,
that I last saw him alive on Sept 21, 1915,

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH was as follows:

Hyphoid Fever

(Duration) yrs. mos. ds.

Contributory
Secondary

(Signed) H. C. Connaway M. D.
Sept 21, 1915 (Address) Hebron, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)At place _____
of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence.**19 PLACE OF BURIAL OR REMOVAL** Mardella Spring DATE OF BURIAL Sept 23, 1915**20 UNDERTAKER** A. L. SeabrookADDRESS Mardella Spring

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations, a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dock laborer*, *Farm laborer*, *Laborer-Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupant has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., or..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT. 6 1915

BUREAU, U. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Wicomico 16019

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 323

Village or City Salisbury (No. Salisbury Dist) St. 9 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Louis Evans

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>a. a.</u>	5 SINGLE, - <u>Single</u> MARRIED, WIDOWED, OR DIVORCED (Write the word)
---------------------	------------------------------	--

6 DATE OF BIRTH <u>February 12</u> (Month) <u>Day</u> <u>1915</u> (Year)
--

7 AGE <u>7 yrs. 7 mos. 18 ds.</u>	IF LESS than 1 day.....hrs. OR.....min.?
-----------------------------------	--

8 OCCUPATION (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) <u>Wicomico Co. Md</u>

10 NAME OF FATHER <u>Sophas Evans</u>
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>
12 MAIDEN NAME OF MOTHER <u>Dixie James</u>
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Evans

(Address) <u>Present Salisbury, Md</u>
--

15 FHD <u>Sept. 30", 1915</u> N. P. Turner
--

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 30", 1915

(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Poly Tyrewood to Salisbury, Md 9-30, 1915,that I last saw him alive on 1915,and that death occurred on the date stated above at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic bronchitis(Duration) yrs. 7 mos. 18 ds.Contributory
Secondary(Duration) yrs. mos. ds.(Signed) H. V. Hester, M.D.
(Address) Salisbury, Md

State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____
of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ dsWhere was disease contracted,
If not at place of death?Former or
usual residence.19 PLACE OF BURIAL OR REMOVAL Rock Creek Cemetery, Co. DATE OF BURIAL Sept. 2, 191520 UNDERTAKER J. J. Stewart ADDRESS Salisbury, Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

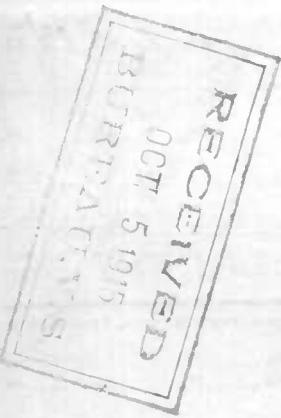
(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Houseward*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease

causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcin-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, "as fracture of skull, and consequences (e. g., *sensus, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Baltimore

16020

1b4

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 337

St. _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Baltimore (No.)2 FULL NAME George Edison Turbush

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
<u>Male</u>	<u>White</u>	<u>Single</u>

6 DATE OF BIRTH	July 26	(Month)	Day	Year
-----------------	---------	---------	-----	------

7 AGE	yrs. <u>2</u>	mos. <u>20</u>	ds. <u>0</u>	If LESS than 1 day, hrs. OR min. ?
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8 OCCUPATION	(a) Trade, profession, or particular kind of work.
	<u>c</u>
	(b) General nature of industry, business, or establishment in which employed (or employer)
	<u>c</u>

9 BIRTHPLACE (State or country)	<u>Maryland</u>
------------------------------------	-----------------

10 NAME OF FATHER	<u>George W. Turbush</u>
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11 BIRTHPLACE OF FATHER (State or country)	<u>Maryland</u>
--	-----------------

12 MAIDEN NAME OF MOTHER	<u>Mary Anna Turbush</u>
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13 BIRTHPLACE OF MOTHER (State or country)	<u>Maryland</u>
--	-----------------

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	
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(Informant)	<u>Geo. W. Turbush</u>
-------------	------------------------

(Address)	<u>Baltimore</u>
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15	Sept. 20, 1915
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Filed	<u>Lucy J. Hallie</u>
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REGISTRAR	
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MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH	Sept 19	(Month)	1915	(Year)
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17 I HEREBY CERTIFY, That I attended deceased from	Sept 10	, 1915, to	Sept 19	, 1915,
--	---------	------------	---------	---------

that I last saw him alive on	Sept 19	, 1915,
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and that death occurred on the date stated above, at	1 P.M.
--	--------

The CAUSE OF DEATH* was as follows:	malnutrition
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acute intestinal indigestion	.
------------------------------	---

(Duration)	yrs. <u>0</u>	mos. <u>0</u>	ds. <u>0</u>
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Contributory Secondary	(Duration)	yrs. <u>0</u>	mos. <u>0</u>	ds. <u>0</u>
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(Signed)	<u>J. W. Turbush</u>	(Address)	M. D.
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Sept 19, 1915	<u>M. D.</u>
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* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
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<u>Baltimore</u>	<u>Sept 20, 1915</u>
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Family burial ground	1915
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20 UNDERTAKER	ADDRESS
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<u>C. G. Messick</u>	<u>Baltimore</u>
----------------------	------------------

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*.

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Hæmæria" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Tuberperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT. 5 1915

BUREAU, U. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

County WicomicoVillage or City Salisbury2 FULL NAME Infant Godwin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male4 COLOR OR RACE white5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word) single6 DATE OF BIRTH Aug 16 19157 AGE 1 yrs. 7 mos. 7 ds.If LESS than
1 day, hrs.
OR min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country) Md

PARENTS

10 NAME OF FATHER

Leroy Godwin

11 BIRTHPLACE OF FATHER

(State or country) Md

12 MAIDEN NAME OF MOTHER

Eddie P Jenkins

13 BIRTHPLACE OF MOTHER

(State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leroy Godwin(Address) Salisbury Md

15

Filed Sept. 24, 1915. May Turner

Deputy REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 373[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 24, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

....., 191..., to , 191...,

that I last saw h..... alive on , 191...,

and that death occurred on the date stated above, at 3 p.m.

The CAUSE OF DEATH * was as follows:

had no doctor unwell
from birth and died
with convulsions

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) C. R. Gandy M. D.Sept. 24, 1915 (Address) Salisbury Md* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) WHETHER ACCIDENTAL,
SUICIDAL OR HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

Petersfield

DATE OF BURIAL

Sept. 24, 1915

20 UNDERTAKER

Holloway & Co

ADDRESS

Salisbury Md

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Tiocerry*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer* etc.—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm(s); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urticaria," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, OR AS *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH
County *Hancock Co.*

16023

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *331*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City *Seantico.* (No.)²FULL NAME *Lucilia Gosslee*

PERSONAL AND STATISTICAL PARTICULARS

³ SEX *Female*⁴ COLOR OR RACE *Negro*⁵ SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word) *Widow*⁶ DATE OF BIRTH *No record*(Month) (Day), (Year) *, 1834*⁷ AGE *About 81 years*yrs. *mos.* ds. If LESS than
1 day, hrs.
OR min. ?⁸ OCCUPATION(a) Trade, profession, or
particular kind of work *Retired*(b) General nature of industry,
business, or establishment in
which employed (or employer) *Maryland*⁹ BIRTHPLACE
(State or country) *Maryland*¹⁰ NAME OF
FATHER *Joshua Polk*¹¹ BIRTHPLACE
OF FATHER
(State or country) *Maryland*¹² MAIDEN NAME
OF MOTHER *Henetta Honey*¹³ BIRTHPLACE
OF MOTHER
(State or country) *Maryland*¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE(Informant) *John J. Jones*¹⁵(Address) *Seantico, Md.*

Filed 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH *Sept 8*(Month) *8*, (Year) *1915*¹⁷ HEREBY CERTIFY, That I attended deceased from*Sept 1st*, 1915, to *Sept 8th*, 1915,that I last saw h. e. alive on *Sept 8th*, 1915,and that death occurred on the date stated above, at *9 A.M.*

The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) — yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) *J. D. Carpenter, M.D.**Sept 9, 1915* (Address) *Seantico, Md.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds

Where was disease contracted,
if not at place of death?Former or
usual residence _____¹⁹ PLACE OF BURIAL OR REMOVAL *Seantico, Md.*DATE OF BURIAL *Sept 9, 1915*20 UNDERTAKER *Joe Jones*ADDRESS *Seantico*

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

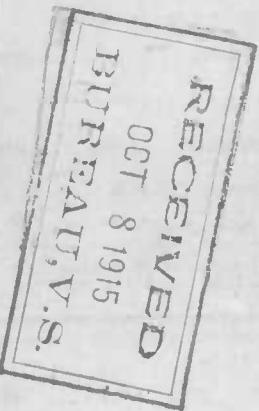
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Tubercular septicemia*," "*Tubercular peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—*accident*; *Revolver wound of head*—*homicide*; *Poisoned by carbolic acid*—*probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement, it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Firceman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmaird*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonacum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Wilmore</u>		16024
Village or City <u>New Salisbury</u> (No.)		<u>Parson St</u> St.; <u>5</u> Ward)
2 FULL NAME <u>Philip</u>		<u>Johnson</u>
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>Male</u>	4 COLOR OR RACE <u>a. a.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>
6 DATE OF BIRTH <u>Sept</u>		<u>23</u> , <u>1913</u> (Month) (Day) (Year)
7 AGE	— yrs — mos — ds.	If LESS than 1 day, <u>3</u> hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Patent</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>/</u>		
9 BIRTHPLACE (State or country) <u>Maryland</u>		
10 NAME OF FATHER <u>Philip Johnson</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
12 MAIDEN NAME OF MOTHER <u>Amelia Hudson</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Philip Johnson</u> (Address) <u>Salisbury Md</u>		
15 Filed <u>Sept 23rd, 1913</u> at N. B. Turner		

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH		
16 DATE OF DEATH <u>Sept 23rd, 1913</u>	(Month)	(Day) (Year)
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,		
that I last saw h. _____ alive on _____, 191____,		
and that death occurred on the date stated above, at 2 p.m.,		
The CAUSE OF DEATH* was as follows: <u>had no doctor</u> <u>premature birth of</u> <u>months</u>		
(Duration) yrs. mos. ds.		
Contributory Secondary		
(Signed) <u>A. P. Smith</u> , M.D. Sept 23, 1913 (Address) <u>Salisbury Md</u>		
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
At place of death yrs. mos. ds. In the State yrs. mos. ds.		
Where was disease contracted, if not at place of death?		
Former or usual residence.		
19 PLACE OF BURIAL OR REMOVAL <u>Salisbury Cemetery</u>		DATE OF BURIAL <u>Sept 24, 1913</u>
20 UNDERTAKER <u>G. Stewart</u>		ADDRESS <u>Salisbury Md</u>

If more blanks are needed, address State Registrar, G. E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Goat milk*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*; *Carcin-*

oma, Sarcoma, etc., of..... (name origin); "Can-
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Masmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensit*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Wisconsin

16025

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 333

Village or City Near Trappe, Md. Trappe Dist. St.; 7 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant of Thomas L Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED

Girl

Anglo-Saxon

Write the word

Single

6 DATE OF BIRTH

Dec 2, 1914
(Month) (Day) (Year)

7 AGE

yrs. 9 mos. 9 ds.

If LESS than
1 day, hrs.
OR min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

none

(b) General nature of Industry
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Md.

PARENTS

10 NAME OF FATHER

Thomas L Jones

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Blanche Causley

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas L Jones

(Address)

Trumland Md.

15

Filed Sept 12, 1915. May Turner
Deputy, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dept. 11, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1915, to Sept 11, 1915,
that I last saw her alive on Sept 11, 1915,
and that death occurred on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH * was as follows:

acute rheumatism

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Jos. L. McLaughlin, M. D.
Sept 11, 1915 (Address) Trumland, Md.* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)At place
of death yrs. mss. ds. In the
Where was disease contracted,
if not at place of death? Stats. yrs. mos. ds.Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

Trumland

DATE OF BURIAL
Sept. 12th 8 P.M., 1915

20 UNDERTAKER

The Hill & Johnson Co., Salisbury
Md.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer in Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *malaria*,

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report more symptoms or terminal conditions, such as "Asthenia," "Anemia," (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urticaria," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent death state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverbér wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH		
County	Wicomico	
Village or City	Nanticoke	
2 FULL NAME Amie B Long		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX Female	4 COLOR OR RACE C	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
6 DATE OF BIRTH		July 24, 1915 (Month) (Day) (Year)
7 AGE	yrs. 2 mos. 6 ds.	If LESS than 1 day, hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) Maryland		
10 NAME OF FATHER	John Wallace	
11 BIRTHPLACE OF FATHER (State or country)	Maryland	
12 MAIDEN NAME OF MOTHER	Frances Wallace	
13 BIRTHPLACE OF MOTHER (State or country)	Md	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant)	John Wallace	
(Address)	Nanticoke	
15	Filed 1st 30, 1915 Lucy J. Waller REGISTRAR	

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 337

189

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 30, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191..., to , 191...,

that I last saw h. alive on , 191...

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bo Diphilus and
attendance

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Lucy J. Waller
Sept 30, 1915 (Address) Nanticoke, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Nanticoke & E. Anthon
3rd mes., 1915

20 UNDERTAKER ADDRESS

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Carcin-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Seizure," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT. 5 1915

REGISTERED, U.S.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uracmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—Homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 5 1915

U. S. CENSUS BUREAU

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		16028
County	Wicomico	
Village or City	Manticoke (No.)	
15		
2 FULL NAME..... Messick		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female	white	Singl
6 DATE OF BIRTH		
Sept 21 (Month) (Day) 1915 (Year)		
7 AGE	If LESS than f day, 2 hrs. yrs. mos. ds. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work. ✓ (b) General nature of industry, business, or establishment in which employed (or employer) ✓		
9 BIRTHPLACE (State or country) Maryland		
10 NAME OF FATHER Gilbourn Frank Messick		
11 BIRTHPLACE OF FATHER (State or country) Maryland		
12 MAIDEN NAME OF MOTHER Pearl H. Messick		
13 BIRTHPLACE OF MOTHER (State or country) Maryland		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. W. Messick, M.D. (Address) Manticoke		
15 Filed Sept 21, 1915 Lucy L. Walter Local. REGISTRAR		

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 337

St. Ward

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 21, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1915, to Sept 21, 1915,

that I last saw him alive on Sept 21, 1915

and that death occurred on the date stated above, at 10 A.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Labor

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) J. W. Messick, M.D.
Sept 21, 1915 (Address) ManticokeState the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-
DENTAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence.19 PLACE OF BURIAL OR REMOVAL
Manticoke Cemetery
DATE OF BURIAL Sept 21, 191520 UNDERTAKER C. G. Messick
ADDRESS Brudenell Rd.

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH**

Approved by U. S. Census and American Public Health

ASSOCIATION.

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement;

it should be used only when needed. As examples:

(a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer-Coachman*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, notably gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer*.

RECEIVED
OCT 5 1915
BUREAU, U.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		16029	STATE OF MARYLAND CERTIFICATE OF DEATH
County	Wicomico	At the P. G. Hospital	Registration Dist. No. 333
Village or City	Salisbury	(No.)	Camden Dist. St. 13 th Ward)
2 FULL NAME		Maudie M. Miller	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED	Married
Female	White	(Write the word)	
6 DATE OF BIRTH			
Oct. 29 th		1894	
(Month) (Day)		(Year)	
7 AGE	It LESS than 1 day, hrs. OR min. ?		
30 yrs. 10 mos. 21 ds.			
8 OCCUPATION			
(a) Trade, profession, or particular kind of work. Housewife			
(b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country)			
Accomac Co. Va.			
10 NAME OF FATHER	William L. Ellam		
11 BIRTHPLACE OF FATHER (State or country)	Virginia		
12 MAIDEN NAME OF MOTHER	Sarah B. Burdick		
13 BIRTHPLACE OF MOTHER (State or country)	Virginia		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			
(Informant)	Maudie Miller		
(Address)	200 W. P. O. Accomac Co. Va.		
15 Filed	Sept. 20, 1915		
<i>At the P. G. Hospital</i>			
16 DATE OF DEATH			
Sept. 20		1915	
(Month)		(Day)	
17 I HEREBY CERTIFY, That I attended deceased from			
Sept. 20, 1915		to Sept. 20, 1915	
that I last saw her alive on Sept. 20, 1915			
and that death occurred on the date stated above, at 4:00 p.m.			
The CAUSE OF DEATH* was as follows:			
Choking from <i>sea grape berries</i>			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)			
At place of death yrs. mos. ds. In the State yrs. mos. ds.			
Where was disease contracted, if not at place of death? Accomac Co. Va.			
Former or usual residence Accomac Co. Va.			
19 PLACE OF BURIAL OR REMOVAL			
Dairby Accomac Co. Va.		DATE OF BURIAL Sept. 21st, 1915	
20 UNDERTAKER			
Deputy, REGISTRAR			
ADDRESS			
Buried by The Hill & Johnson Co. Salisbury Md.			

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Seizure," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malnutrition," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

V. S. No. 1.
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1 PLACE OF DEATH County <i>Wicomico</i>		16030	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <i>Salisbury</i>		(No. <i>Camden St.</i>) St.; <i>13</i> Ward)	Registration Dist. No. <i>333</i>	
2 FULL NAME <i>Eva Moore</i>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <i>Female</i>	4 COLOR OR RACE <i>Black</i>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <i>single</i>		
6 DATE OF BIRTH <i>No record of birth</i>	(Month) <i>1903</i>	(Day) <i>1</i>	(Year) <i>1903</i>	
7 AGE <i>12 yrs.</i>	<i>6 mos.</i>	<i>15 ds.</i>	It LESS than 1 day, hrs. OR min.?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>School girl</i>				
(b) General nature of industry business, or establishment in which employed (or employer) <i>None</i>				
9 BIRTHPLACE (State or country) <i>Md</i>				
PARENTS	10 NAME OF FATHER <i>Noah Moore</i>	11 BIRTHPLACE OF FATHER (State or country) <i>Md</i>	12 MAIDEN NAME OF MOTHER <i>Annie Walker</i>	13 BIRTHPLACE OF MOTHER (State or country) <i>Md</i>
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>E. J. Moore</i> (Address) <i>Bivalley Md</i>				
15 Filed <i>Sept 3rd 1915</i> by <i>W. W. Turner</i>				
REGISTRAR				
16 MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <i>Sept 3 1915</i>				
17 I HEREBY CERTIFY, That I attended deceased from <i>Aug 23 1915</i> to <i>Sept 3 1915</i> , that I last saw her alive on <i>Sept 3 1915</i> , and that death occurred on the date stated above, at <i>11 A.M.</i> The CAUSE OF DEATH was as follows:				
<i>Benign plethora</i>				
(Duration) <i>1 day</i>				
Contributory <i>Gangrenous appendicitis</i> Secondary <i>Inflammation</i>				
(Signed) <i>J. H. Moore</i> (Address) <i>Bivalley Md</i> M. D. <i>Sept 3 1915</i>				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State, yrs. mos. ds.				
Where was disease contracted, if not at place of death? Former or usual residence <i>Mcminn Co. Md</i> <i>Mcminn Co. Md</i>				
19 PLACE OF BURIAL OR REMOVAL <i>Wicomico Md</i> DATE OF BURIAL <i>Sept 4 1915</i>				
20 UNDERTAKER <i>Holloway & Sons</i> ADDRESS <i>Salisbury Md</i>				

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonacum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility" ("Con-genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OR INJURY AND QUALIFY AS ACCIDENTAL, SUICIDAL, OR HOMICIDAL, OR AS *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH
County Hanover

16931

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 335

63

Village or City near Sharptown (No.)2 FULL NAME Herbert R. Nichols

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
-------------------	------------------------------	--

6 DATE OF BIRTH Oct 19(Month) (Day), (Year) 19127 AGE 2 yrs. 11 mos. 0 ds.If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country) West Va.10 NAME OF FATHER Herbert Nichols11 BIRTHPLACE OF FATHER
(State or country) West Va.12 MAIDEN NAME OF MOTHER Maggie E. Morgan13 BIRTHPLACE OF MOTHER
(State or country) West Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herbert Nichols(Address) Riverton, Md.

15

Filed 9, 191

REGISTRAR

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 19(Month) (Day), (Year) 1915

17 I HEREBY CERTIFY, That I attended deceased from

Sept 18, 1915, to Sept 19, 1915,that I last saw him alive on Sept 19, 1915,and that death occurred on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis(Duration) 1 yrs. 0 mos. 0 ds.Contributory
Secondary(Duration) 0 yrs. 0 mos. 0 ds.(Signed) C. E. Jones, M. D.Sept 20, 1915 (Address) Sharptown, Md.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds

Where was disease contracted.

If not at place of death?

Former or
usual residence.19 PLACE OF BURIAL OR REMOVAL RivertonDATE OF BURIAL Sept 20, 191520 UNDERTAKER W. W. Gravencourt, Jr., SharptownADDRESS Sharptown, Md.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dairy laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 6 1915

INTERIMAT. V.S.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

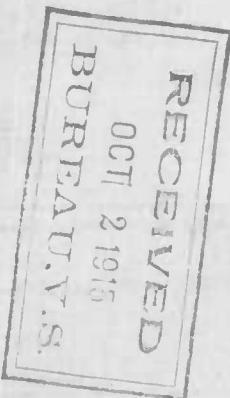
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm labore, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc., Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Broncho-pneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Contingent," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranquilla," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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MARGIN RESERVED FOR BINDING

V. S. No. 1.

N. B.— Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Hanover Co

16033

STATE OF MARYLAND
CERTIFICATE OF DEATH

3321

Registration Dist. No.

79

Village or City R.D. Salisbury md2 FULL NAME James M. Ralph

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	White	Widower

6 DATE OF BIRTH No record except year, 1843
(Month) (Day) (Year)

7 AGE 72 yrs. — mos. — ds.
If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION
 (a) Trade, profession, or
particular kind of work
 (b) General nature of industry
business, or establishment in
which employed (or employer)

9 BIRTHPLACE
(State or country)

10 NAME OF FATHER
Dont Know

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER
Dont Know

13 BIRTHPLACE OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarah Jefferson

(Address) R.D. - Salisbury md

15 Filed Sept. 7, 1915 H. J. Traill
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 5, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1915, to Sept 5, 1915,
that I last saw h alive on _____, 1915,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

Mental Degeneration

Contributory
Secondary Pellagra
(Duration) 2 yrs. 6 mos. 0 ds.

(Signed) H. J. Traill (Address) Baltimore, Md
(Duration) 1 yrs. 1 mos. 0 ds.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds.
Where was disease contracted,
if not at place of death?

In the State, yrs. mos. ds.
Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Ralph Hill DATE OF BURIAL September 7, 1915

20 UNDERTAKER J. Ratliff Harlow ADDRESS Ward's md

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

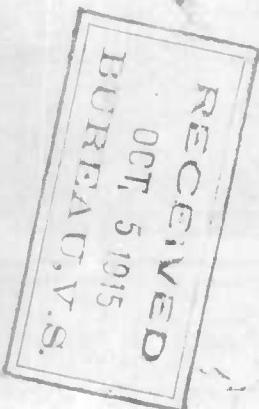
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer — Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonium*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic rubor heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County		16034 <i>P.G. Hospital</i>	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City		(No.)	Registration Dist. No. 333 St. 13 Ward	
2 FULL NAME		<i>Helen Retchie</i>		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	6 STATION	
Male	White	MARRIED	stition	
7 DATE OF BIRTH		Sept. 25, 1915	(Month)	(Day)
			(Year)	
8 AGE	9 BIRTHPLACE (State or country)	10 NAME OF FATHER		
6 mos. unknown	Worcester Co., Md.	Hans Retchie		
YRS.	MOS.	ds.	11 BIRTHPLACE OF FATHER (State or country)	
			Worcester Co., Md.	
12 PARENTS	13 BIRTHPLACE OF MOTHER (State or country)	14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
	Bessie Brittingham	(Informant) <i>John</i> (Address) <i>Salisbury, Md.</i>		
15	Filed <i>Sept 25th, 1915</i> by <i>S. N. P. Turner</i>	REGISTRAR		
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.				
[If death occurred in a hospital or institution, give its NAME instead of street and number.]				
16 DATE OF DEATH <i>Sept 25, 1915</i>				
I HEREBY CERTIFY That I attended deceased from <i>Sept. 25, 1915</i> to <i>Sept. 25, 1915</i> , now that I last saw him alive on <i>an unknown date</i> , and that death occurred on the date stated above, at <i>Salisbury, Md.</i>				
The CAUSE OF DEATH* was as follows: <i>Unknown</i>				
(Duration) yrs. mos. ds.				
Contributory <i>Unknown</i> Secondary				
(Duration) yrs. mos. ds.				
(Signed) <i>J. M. Turner</i> , M. D. (Address) <i>Salisbury, Md.</i>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)				
At place In the <i>Lifetime</i> of death yrs. mos. 3 ds. State yrs. mos. ds				
Where was disease contracted, if not at place of death? <i>Wor. Custer Co. Md.</i>				
Former or usual residence <i>Wor. Custer Co. Md.</i>				
19 PLACE OF BURIAL OR REMOVAL <i>P.G. Hospital</i> DATE OF BURIAL <i>Sept 25th, 1915</i>				
20 UNDERTAKER <i>Superintendent</i> ADDRESS <i>Mrs. Green, Salisbury, Md.</i>				

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "laborer," "foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Hauskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causino death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer*.

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis, tefanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

V. S. No. 1.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

Wicomico
County

16035

74

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City near Salisbury (No. Streets Dist. St.; 8 Ward)

2 FULL NAME

John Knark

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED.
(Write the word)

male

White

Widower

6 DATE OF BIRTH

Oct 23, 1833
(Month) (Day) (Year)

7 AGE

81 yrs. 10 mos. 26 ds.

If LESS than
1 day, hrs.
OR min.?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF FATHER

John Knark

11 BIRTHPLACE OF FATHER
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Sallie Richardson

13 BIRTHPLACE OF MOTHER
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lee Knark

(Address) Salisbury Md R D #4

15

Filed Sept. 20, 1915; May Turner

Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 19th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1915, to July 4th, 1915, that I last saw him alive on July 4th, 1915, and that death occurred on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH was as follows:

only saw him his wife and
do not history since above date
know
Infirmities of age don't find
Contributory
Secondary

Heart (Valvular disease)
(Duration) Not known
yrs. mos. ds.

(Signed) G. W. Todd, M.D.
Sept 19th, 1915 (Address) Salisbury Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2), whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds.
Where was disease contracted,
If not at place of death?

Former or
usual residence

In the
State, yrs. mos. ds.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Ernest Dykes grave 8-Boyle Sept 20, 1915

20 UNDERTAKER

Holloway & Co ADDRESS
Salisbury Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer in Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housekeeper*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmend*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges

(name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*, *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Aatrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Urticaria," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and QUALITY as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH		16036
County	Frederick	
Village or City	Pittsville (No.)	
2 FULL NAME <i>Emma Smith</i>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>widow</i> (Write the word)
<i>Female White</i>		
6 DATE OF BIRTH	7 AGE	8 OCCUPATION
9/18/1878	86 yrs. 11 mos. 36 ds.	(a) Trade, profession, or particular kind of work. <i>Housewife</i>
(b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country)	10 NAME OF FATHER	11 BIRTHPLACE OF FATHER (State or country)
Sussex Co.	Jehu Heath	Sussex Co.
12 MAIDEN NAME OF MOTHER	13 BIRTHPLACE OF MOTHER (State or country)	14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Ellen Pepper	House & Co.	(Informant) <i>Emma Smith Sheppard</i> (Address) <i>Pittsville Md.</i>
15	Filed 191	16 <i>P James Trustt</i> REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 14, 1915

I HEREBY CERTIFY, That I attended deceased from *no date*, 1915, to *no date*, 1915, that I last saw h. alive on *dead on arrival*, 1915, and that death occurred on the date stated above, at *9 AM*. m. The CAUSE OF DEATH★ was as follows:

Apoplexy

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) *L Green*, M. D.
9-16, 1915 (Address) *Pittsville Md.*

★State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pittsville M. P. Cemetery Sept 1915

20 UNDERTAKER ADDRESS

H. P. Parsons Pittsville Md.

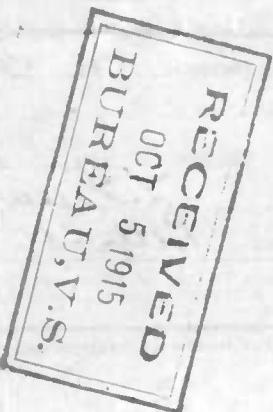
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Hausekeepers* who receive a definite salary), may be entered as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH	
County	Wicomico
Village or City	Hebron
2 FULL NAME Paul Taylor	
PERSONAL AND STATISTICAL PARTICULARS	
3 SEX	4 COLOR OR RACE
Male	White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED	
(Write the word)	
6 DATE OF BIRTH	
April 30th, 1915	
(Month)	(Day)
(Year)	
7 AGE	If LESS than 1 day, hrs. OR min.?
4 yrs. 4 mos. 20 ds.	
8 OCCUPATION	
(a) Trade, profession, or particular kind of work.	
None	
(b) General nature of industry, business, or establishment in which employed (or employer)	
9 BIRTHPLACE (State or country)	
Hebron Md.	
10 NAME OF FATHER	Winfield S. Taylor
11 BIRTHPLACE OF FATHER (State or country)	Somerset Co. Md.
12 MAIDEN NAME OF MOTHER	Sarah E. Leansay
13 BIRTHPLACE OF MOTHER (State or country)	Wicomico Co. Md.
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	
(Informant)	Winfield S. Taylor
(Address)	Hebron Md.
15	Filed Sept 21, 1915 H. S. Phillips

16037

104

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 358

Hebron Dist

St. 15 Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 20, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1915, to Sept 20, 1915,

that I last saw him alive on Sept 6, 1915,

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Auto colli-

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) J. Morris Colehurst, M.D.
Sept 20, 1915 (Address) Salisbury, Md.

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Selby Cemetery, Hebron, Md. DATE OF BURIAL Sept 21, 1915

20 UNDERTAKER

The Hill & Johnson Co. ADDRESS Salisbury, Md.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

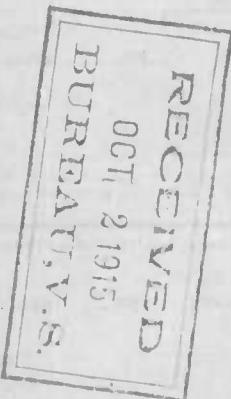
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs*, *meninges*, *peritonacum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Confidential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malnutrition," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Wicomico

16038

164

STATE OF MARYLAND.
CERTIFICATE OF DEATHRegistration Dist. No. 338St. 15th Ward)

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

Village or City Hebron (No.)**2 FULL NAME** Pauline Taylor

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female **4 COLOR OR RACE** White **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Single
(Write the word)

6 DATE OF BIRTH April 80th, 1915
(Month) (Day) (Year)

7 AGE 4 yrs. 4 mos. 21 ds. If LESS than
1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or
particular kind of work. None
(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE
(State or country) Hebron Md

10 NAME OF FATHER Winfield S. Taylor

11 BIRTHPLACE OF FATHER
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah E. Causey

13 BIRTHPLACE OF MOTHER
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Winfield S. Taylor
(Address) Hebron Md

15
Filed Sept 22, 1915 by B. S. Phillips

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 21, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
Sept 6, 1915, to Sept 21, 1915,

that I last saw him alive on Sept 6, 1915,

and that death occurred on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

See Coroner
(Duration) yrs. mos. ds.

Contributory
Secondary

(Signed) James Pugh, M. D.
Sept 21, 1915 (Address) Leesburg, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL Hebron Md. **DATE OF BURIAL** Sept 22, 1915

20 UNDERTAKER The Hill & Johnson Co. **ADDRESS** Salisbury Md.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially, in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menses, peritonacum, etc., Cancer*;

oma, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d^s; *Bronchopneumonia* (secondary), 10 d^s. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Cachectic," "Seuile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railroad train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED OCT 2 1917	1
BUREAU, W. S.	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Hanover</u>		16039 <i>(64)</i>	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Salisbury</u> (No. <u>Salisbury Dist.</u>)		Registration Dist. No. <u>333.</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]
St. <u>9</u> Ward)				
2 FULL NAME <u>Ernest A. Goadvine</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDDLED, DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>Sept 13</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>Oct. 14</u> (Month) (Day) (Year)		MEDICAL CERTIFICATE OF DEATH		
7 AGE <u>54 yrs. 10 mos. 29 ds.</u>	It LESS than 1 day, hrs. OR..... min. ?		17 I HEREBY CERTIFY, That I attended deceased from <u>Sept 13</u> , 1915, to <u>Sept 13</u> , 1915, that I last saw him alive on <u>Sept 13</u> , 1915, and that death occurred on the date stated above, at <u>9.30 a.m.</u> The CAUSE OF DEATH* was as follows:	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Clerk of Circuit Court</u>		<u>Cerebral Hemorrhage</u> <u>Temporary</u> (Duration) <u>yrs. mos. ds.</u>		
9 BIRTHPLACE (State or country) <u>Salisbury, Md</u>		Contributory Secondary		
10 NAME OF FATHER <u>Stephen P. Goadvine</u>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place _____ of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.		
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		Where was disease contracted, if not at place of death? _____		
12 MAIDEN NAME OF MOTHER <u>Marta Quark</u>		Former or usual residence _____		
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		19 PLACE OF BURIAL OR REMOVAL <u>Parsons Cemetery, Salisbury</u> DATE OF BURIAL <u>9/15/15, 1915</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Ernest A. Goadvine,</u> (Address) <u>Salisbury, Md.</u>				
15 Filed <u>Sept. 13, 1915</u> by <u>Mary Turner</u> Supt. REGISTRAR		20 UNDERTAKER <u>The Hill & Johnson Co.</u> ADDRESS <u>Salisbury, Md.</u>		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinosis*.

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Thenia," "Collapse," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED	OCT 5 1915
BUREAU U.S.	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Hanover

16940

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 338

(XO)

St. _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Hebron (No.)2 FULL NAME David L. Grader

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
<u>Male</u>	<u>White</u>	<u>Married</u>

6 DATE OF BIRTH	May	5	, 1842.
	(Month)	(Day)	(Year)

7 AGE	73	yrs. 4	mos. 20	ds.	It LESS than 1 day, _____. hrs. OR _____. min. ?
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8 OCCUPATION	<u>Labourer</u>
(a) Trade, profession, or particular kind of work.	
(b) General nature of industry, business, or establishment in which employed (or employer)	

9 BIRTHPLACE (State or country)	<u>Maryland</u>
------------------------------------	-----------------

10 NAME OF FATHER	<u>Samuel Grader</u>
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11 BIRTHPLACE OF FATHER (State or country)	<u>Maryland</u>
---	-----------------

12 MAIDEN NAME OF MOTHER	<u>Maria Townsend</u>
--------------------------	-----------------------

13 BIRTHPLACE OF MOTHER (State or country)	<u>Maryland</u>
---	-----------------

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	<u>I. D. Bailey</u>
(Informant)	<u>Hebron</u>

(Address)	<u>Hebron</u>
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15	Sept 25, 1915	H. S. Phillips
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REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 25, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1915, to Sept 25, 1915, that I last saw him alive on Sept 25, 1915, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach & nephritis

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) H. C. Commaway, M. D.
Sept 25, 1915 (Address) Hebron md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Hebron Cemetery DATE OF BURIAL Sept 27, 1915

20 UNDERTAKER The Hill & Johnson Co ADDRESS Salisbury, Md.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Contingent," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railroad train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 2 1915	BUREAU, U.S.
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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Wicomico 16041
164

Village or City Willards (No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 332

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Holly E. Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u> (Write the word)
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6 DATE OF BIRTH

April 22, 1813
(Month) (Day) (Year)

7 AGE

0 yrs., 4 mos., 18 ds.
If LESS than
1 day, hrs.
OR min.?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Temelia Smith(Address) Willards Md.

15

Filed , 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 9, 1915
(Month) (Day) (Year)

17 HEREBY CERTIFY, That I attended deceased from Apr 22, 1915 to Sept. 9, 1915,

that I last saw her alive on Sept. 5, 1915, and that death occurred on the date stated above, at 7 a.m.

The CAUSE OF DEATH is as follows:

Gastroenteritis
(Duration) yrs. / mos. ds.

Contributory
Secondary

Hemorrhage Birth
(Duration) yrs. / mos. ds.

(Signed)

C. A. Holland, M. D.
Sept. 10, 1915 (Address) Whaleysville Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mss. ds.
Where was disease contracted,
if not at place of death?

Former or usual residence

In the State, yrs. mss. ds.

19 PLACE OF BURIAL OR REMOVAL

New Hope

DATE OF BURIAL

Sept 10, 1915

20 UNDERTAKER

J. Ratliff Farlow

ADDRESS

Willards

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonitis*, etc. *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED	OCT 5 1915
BUREAU V.S.	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Wicomico 16042

Village or City Tyaskin (No.)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 8357

St. _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Charlotte M. Wainright

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>C</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
---------------------	--------------------------	--

6 DATE OF BIRTH May 23, 1914
(Month) (Day) (Year)

7 AGE <u>1 yrs 3 mos 23 ds.</u>	If LESS than 1 day, ____ hrs. OR ____ min. ?
---------------------------------	--

8 OCCUPATION
(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country) Maryland

10 NAME OF FATHER John R. Wainright

11 BIRTHPLACE OF FATHER
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eveline Jones

13 BIRTHPLACE OF MOTHER
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. R. R. Wainright

(Address) Tyaskin Md

15 Filed: Sept. 14, 1915 S. Lucy J. Walter Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 13, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 12th, 1915 to Sept 12th, 1915, 1915.

that I last saw h. u alive on Sept 12th, 1915.

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Diarrhoea, Enteritis

(Duration) 115 days

Contributory
Secondary

(Signed) R. E. Radwill (Duration) 115 days
(Address) Bivalve Md. M. D.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Tyaskin Md. Cemetery DATE OF BURIAL Sept 14, 1915

20 UNDERTAKER G. G. Merick ADDRESS Bivalve Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, Cotton mill;* (a) *Salesman, (b) Grocery;* (a) *Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the disease

causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles;* *Whooping cough;* *Chronic valvular heart disease;* *Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapsus," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia,*" "*Puerperal peritonitis,*" etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning;* *Struck by railway train—accident;* *Revolver wound of head—homicide;* *Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sensus, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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R E C - V . E D

OCT. 5 1915

BUREAU, U. S. S.

MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

¹ PLACE OF DEATH County <i>Wicomico</i>		16943
Village or City <i>Salisbury</i>		P. G. Hospital (No. <i>186</i>)
		Camden Dist. St.; 13 th Ward)
² FULL NAME <i>George W. Ward</i>		
PERSONAL AND STATISTICAL PARTICULARS		
³ SEX <i>Male</i>	⁴ COLOR OR RACE <i>White</i>	⁵ SINGLE, MARRIED, WIDDED, DIVORCED (Write the word) <i>Married</i>
⁶ DATE OF BIRTH <i>May 2</i>		(Month) (Day) (Year) <i>1854</i>
⁷ AGE <i>61 yrs. 4 mos. 14 ds.</i>	If LESS than 1 day, hrs. OR min. ?	
⁸ OCCUPATION <i>Farmer</i>		
(a) Trade, profession, or particular kind of work		
(b) General nature of industry, business, or establishment in which employed (or employer)		
⁹ BIRTHPLACE (State or country) <i>Virginia</i>		
¹⁰ NAME OF FATHER <i>Charles Ward</i>		
¹¹ BIRTHPLACE OF FATHER (State or country) <i>Virginia</i>		
¹² MAIDEN NAME OF MOTHER <i>Not Known</i>		
¹³ BIRTHPLACE OF MOTHER (State or country) <i>W.M.</i>		
¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>W. E. Tull</i> (Address) <i>Glocke's Md.</i>		
15 Filed <i>Sept 16, 1915; May Turner,</i> <i>Deputy, REGISTRAR</i>		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *333*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH		
¹⁶ DATE OF DEATH <i>Sept 16, 1915</i>	(Month) <i>Sept</i>	(Day) <i>16</i> , (Year) <i>1915</i>
I HEREBY CERTIFY, That I attended deceased from <i>Oct 11, 1915</i> to <i>Sept 16, 1915</i> ,		
that I last saw him alive on <i>Sept 16, 1915</i> ,		
and that death occurred on the date stated above, at <i>8:20 A.m.</i>		
The CAUSE OF DEATH* was as follows:		
<i>General paralysis</i>		
(Duration) <i>1 yr. 11 mos. 11 ds.</i>		
Contributory <i>Gangrenous appendicitis</i> Secondary <i>Influenza</i>		
(Duration) <i>1 yr. 11 mos. 11 ds.</i>		
(Signed) <i>M. W. Ward</i> , M. D. Sept 16, 1915 (Address) <i>Salisbury, Md.</i>		
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and, (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place _____ of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ Where was disease contracted, _____ If not at place of death? _____ Former or usual residence _____		
¹⁹ PLACE OF BURIAL OR REMOVAL <i>To Harsley Worcester Co. Md.</i> DATE OF BURIAL <i>Sept 18th, 1915</i>		
²⁰ UNDERTAKER <i>The Hill & Johnson Co. Salisbury Md.</i> ADDRESS		

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

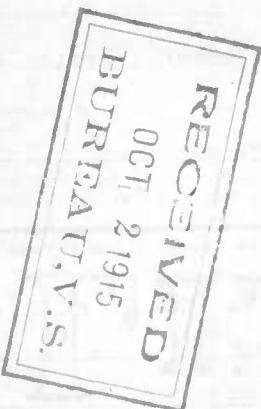
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PLACE OF DEATH
County Wicomico

16045

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333Village or City Salisbury

(No.)

Camden Dist.St. 1A Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary West

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)Married6 DATE OF BIRTH Aug 18

(Month)

(Day)

(Year)

7 AGE 36 yrs.

mos.

7

ds.

If LESS than
1 day, hrs.
OR min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work Housewife(b) General nature of industry
business, or establishment in
which employed (or employer)9 BIRTHPLACE
(State or country) Md

PARENTS

10 NAME OF
FATHER Unknown11 BIRTHPLACE
OF FATHER
(State or country)12 MAIDEN NAME
OF MOTHER Leah E Gray13 BIRTHPLACE
OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John B West(Address) Salisbury Md

15

Filed Sept 27, 1915 May Funeral

Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 25

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1915, to Sept. 25, 1915, that I last saw her alive on Sept. 25, 1915, and that death occurred on the date stated above, at 5 P. m. The CAUSE OF DEATH* was as follows:

Post mortem
Tuberous Pneumonia

(Duration) yrs. mos. ds.

Contributory Heart Failure
Secondary

(Duration) yrs. mos. ds.

(Signed) John B West M. D.(Address) Salisbury Md

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Prisons CemeteryDATE OF BURIAL Sept 27, 191520 UNDERTAKER Holloway & CoADDRESS Salisbury Md

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid* fever (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia"; unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*, *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urticaria," "Weakness," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and QUALITY as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, OR AS PROBABLY SUCH, IF IMPOSSIBLE TO DETERMINE DEFINITELY. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Wicomico</u>		16046	53	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Salisbury</u>		(No.)	<u>Salisbury Dist.</u>	St. <u>9th</u>	Registration Dist. No. <u>333</u>
St., <u>9th</u> Ward)					
2 FULL NAME <u>Elizabeth Whitney</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u>	MEDICAL CERTIFICATE OF DEATH		
6 DATE OF BIRTH <u>May</u>		18	16 DATE OF DEATH <u>Sept. 27</u>	1915	(Year)
		(Month)	(Day)	(Month)	(Day)
7 AGE <u>80</u>	80 yrs.	4 mos.	9 ds.	IT LESS than 1 day, hrs. OR min. ?	(Year) <u>1915</u>
8 OCCUPATION (a) Trade, profession, or particular kind of work... <u>None</u>					
(b) General nature of industry, business, or establishment in which employed (or employer) <u>Housewife</u>					
9 BIRTHPLACE (State or country) <u>Virginia</u>					
10 NAME OF FATHER <u>John Williams</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>					
12 MAIDEN NAME OF MOTHER <u>Nancy Danson</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Virginia</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>A. E. Booth</u> (Address) <u>Salisbury Md.</u>					
15 Filed <u>Sept. 28, 1915</u> by <u>Mary Turner</u> Dolbury REGISTRAR					
16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place _____ of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds Where was disease contracted, if not at place of death? _____					
Former or usual residence _____					
17 PLACE OF BURIAL OR REMOVAL <u>Mt. Vernon Somerset Co. Md.</u> DATE OF BURIAL <u>Sept. 29th, 1915</u>					
18 UNDERTAKER <u>The Hull & Johnson Co.</u> ADDRESS <u>Salisbury Md.</u>					

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[If death occurred in a hospital or institution, give its NAME instead of street and number.]

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1 PLACE OF DEATH County <u>Awemeico</u>		16047	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Near Delmar</u> (No.)		Registration Dist. No. <u>336</u>		<i>DX 110</i>
St.: Ward)		[If death occurred in a hospital or institution, give its NAME instead of street and number.]		
2 FULL NAME <u>Frances Williams</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>A.A.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCE <u>yes</u> (Write the word)	16 DATE OF DEATH <u>Sept 4, 1915</u>	
6 DATE OF BIRTH <u>1873</u> (Month) (Day) (Year)		17 I HEREBY CERTIFY, That I attended deceased from 191... to 191... that I last saw h <u>er</u> alive on <u>July 1st</u> , 1915 and that death occurred on the date stated above, at 7 P.M. The CAUSE OF DEATH* was as follows:		
7 AGE <u>about 42 yrs</u> mos. ds.		If LESS than 1 day, hrs. OR min. ?	<u>Albemarria</u> <u>Chronic nephritis</u> <u>P.U.B</u>	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Dom Housework</u>		<u>Daut Kuan</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		<u>Daut Kuan</u>		
9 BIRTHPLACE (State or country) <u>North Carolina</u>		Contributory Secondary	<u>Duration) yrs. mos. ds.</u>	
10 NAME OF FATHER <u>John Savage</u>		<u>Robert Ellegood</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>North Carolina</u>		<u>Sept 10th, 1915 (Address) Delmar Del</u>		
12 MAIDEN NAME OF MOTHER <u>unknown</u>		* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.		
13 BIRTHPLACE OF MOTHER (State or country) <u>Arkansas</u>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Amelia Jones</u>		At place of death yrs. mos. ds. In the Where was disease contracted, If not at place of death? Former or usual residence.		
(Address) <u>Delmar Del. Md.</u>		19 PLACE OF BURIAL OR REMOVAL <u>Union Cemetery</u> DATE OF BURIAL <u>Sept 18, 1915</u>		
15 Filed <u>Sept 8, 1915</u> by <u>W. Y. Dunn</u>		20 UNDERTAKER <u>L. J. Stewart</u> ADDRESS <u>Salisbury, Md.</u>		
REGISTRAR				
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.				

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Confusional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 2 1915

BUREAU, U. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Hanover

16048

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 330

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Mardela Spgs.

14P

Nancy M. Wilson

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, DIVORCED (Write the word) <u>Married</u>
6 DATE OF BIRTH <u>Nov 18, 1856</u> (Month) (Day) (Year)		
7 AGE <u>58 yrs. 10 mos. 13 ds.</u> If LESS than 1 day, _____.hrs. OR _____.min.?		

8 OCCUPATION
 (a) Trade, profession, or particular kind of work House Wife
 (b) General nature of Industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country) Hanover Co.

10 NAME OF FATHER Benjamin G. Graveson
 11 BIRTHPLACE OF FATHER Hanover Co.
 12 MAIDEN NAME OF MOTHER Eleanor Bennett
 13 BIRTHPLACE OF MOTHER Hanover Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William P. Wilson

(Address) Edge Water, Md.

15

Filed 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 5, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from Sept 3, 1915 to Sept 5, 1915,
that I last saw her alive on Sept 3, 1915,

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) H. C. Cornaway, M. D.
Sept 6, 1915 (Address) Hebron, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

Mardela SpgsDATE OF BURIAL
Sept 8, 1915

20 UNDERTAKER

H. C. Graveson & Son

ADDRESS

Sharpstown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

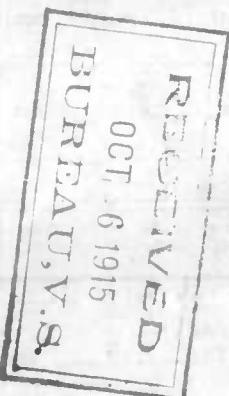
(a) *Spinner*, (b) *Cotton mill*; (a) *Saltzman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return “*Laborer*,” “*Foreman*,” “*Manager*,” “*Dealer*,” etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Houscwife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is “*Epidemic cerebrospinal meningitis*”); *Diphtheria* (avoid use of “*Group*”); *Typhoid fever* (never report “*Typhoid pneumonia*”); *Lobar pneumonia*; *Bronchopneumonia* (“*Pneumonia*,” unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcin-*

oma, Sarcoma

etc., of..... (name origin; “*Cancer*” is less definite; avoid use of “*Tumor*” for malignant neoplasms); *Mastoid*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as “*Anæmia*,” “*Anæmia*” (merely symptomatic), “*Atrophy*,” “*Collapse*,” “*Coma*,” “*Convulsions*,” “*Debility*” (“*Con genital*,” “*Senile*,” etc.), “*Dropsey*,” “*Exhaustion*,” “*Heart failure*,” “*Haemorrhage*,” “*Inanition*,” “*Marasmus*,” “*Old Age*,” “*Shock*,” “*Traæmia*,” “*Weakness*,” etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as “*PUERPERAL septicæ mia*,” “*PUERPERAL peritonitis*,” etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis*, *tetanus*) may be stated under the head of “*Contributory*.” (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Wicomico</u>		16049	66	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>New Salisbury</u> (No. <u>Salisbury Dist.</u>)		St.; P. Ward)	Registration Dist. No. <u>333</u> .		
2 FULL NAME <u>Maryanna Wright</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Afro American</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	MEDICAL CERTIFICATE OF DEATH		
6 DATE OF BIRTH <u>July 28, 1866</u>		16 DATE OF DEATH <u>Sept 10, 1915</u>			
		17 I HEREBY CERTIFY, That I attended deceased from <u>Saturday Aug 25, 1915</u> , to <u>Sunday Aug 26, 1915</u> , that I last saw her alive on <u>Aug 25, 1915</u> , and that death occurred on the date stated above, at <u>10 a.m.</u> The CAUSE OF DEATH * was as follows: <u>Paralysis</u>			
7 AGE <u>49 yrs. 1 mos. 17 ds.</u>		If LESS than 1 day, <u>hrs.</u> OR <u>min. ?</u>			
8 OCCUPATION <u>Housewife</u> (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)		From personal knowledge <u>Aug 25, 1915</u> (Duration) <u>yrs. mos. ds.</u>			
9 BIRTHPLACE <u>Md</u> (State or country)		Contributory Secondary			
10 NAME OF FATHER <u>Nathan Wright</u>		(Duration) <u>yrs. mos. ds.</u>			
11 BIRTHPLACE OF FATHER <u>Md</u> (State or country)		(Signed) <u>M. P. Wark</u> , M. O.			
12 MAIDEN NAME OF MOTHER <u>Maryanna Colman</u>		Address <u>Salisbury Md</u>			
13 BIRTHPLACE OF MOTHER <u>Md</u> (State or country)		* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wilmer Wright</u>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>yrs. mos. ds.</u> Where was disease contracted, if not at place of death ? Former or usual residence			
(Address) <u>Salisbury Md</u>		In the State, <u>yrs. mos. ds.</u>			
15 Filed <u>Sept 11, 1915</u> May Turner, Deputy, REGISTRAR		19 PLACE OF BURIAL OR REMOVAL <u>Alber Md</u> DATE OF BURIAL <u>Sept 12, 1915</u>			
		20 UNDERTAKER <u>Holloway & Co</u> ADDRESS <u>Salisbury Md</u>			

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Musles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal*," "*septichæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Moorise

16050

164

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333Village or City Salisbury(No. Salisbury Dist. St.; 9 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Nellie V Wright

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
<u>Female Afro-American</u>		<u>Single</u>

6 DATE OF BIRTH

Nov 26, 1914
(Month) (Day) (Year)

7 AGE	If LESS than 1 day, hrs. OR min.?
yrs. <u>9</u> mos. <u>23</u> ds.	

8 OCCUPATION

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Md

10 NAME OF FATHER

Daniel Gale11 BIRTHPLACE OF FATHER
(State or country)Md

12 MAIDEN NAME OF MOTHER

Nellie Wright13 BIRTHPLACE OF MOTHER
(State or country)Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nellie Wright

(Address)

708 LakesideSalisbury Md.

15

Filed Sept. 20, 1915. May Timers

Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 19 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191..., to , 191...,

that I last saw h alive on , 191...,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

Had no doctorPettiness + diarrheaInfluenza feeding

(Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) C K Trout M. O.Sep 20, 1915 (Address) Salisbury Md.

* State the DISEASE CAUSING DEATH; or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mes. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Petties Field DATE OF BURIAL Sept 20, 1915

20 UNDERTAKER

Holloway & Co ADDRESS Salisbury Md.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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ges, *peritonacum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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